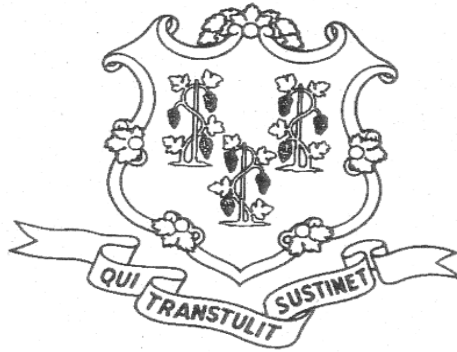


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) HANCOCK HALL	
Address (No. & Street, City, State, Zip Code) 31 STAPLES STREET, DANBURY, CT. 06810	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 2185-C	RHNS	(Specify)	Medicare Provider 07-5414
------------------	----------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 2185	RHNS	ICF-IID
----------------------------	--------------	------	---------

For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

General Information

Name of Facility (as licensed) <i>HANCOCK HALL</i>	License No. <i>21PS-C</i>	Report for Year Ended <i>9/30/2017</i>	Page 1	of 37
---	------------------------------	---	-----------	----------

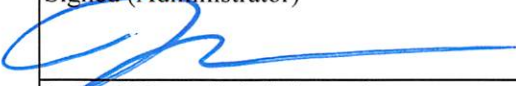
Administrator's/Owner's Certification

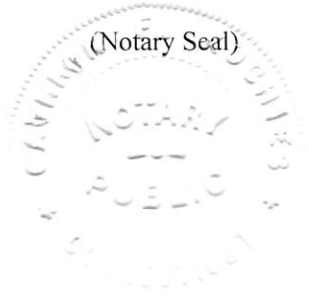
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for *HANCOCK HALL* [facility name], for the cost report period beginning *10/1/16* and ending *9/30/17*, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator) 		Date <i>2/14/18</i>	Signed (Owner) <i>Frank J. Malone</i>		Date <i>2/14/18</i>
Printed Name (Administrator) <i>JENNIFER A MALONE - SEIXAS</i>			Printed Name (Owner) <i>DR. FRANK MALONE</i>		
Subscribed and Sworn to before me:	State of <i>CONNECTICUT</i>	Date <i>2-14-18</i>	Signed (Notary Public) <i>Catherine F. Kochies</i>	Comm. Expires <i>03/31/2022</i>	
Address of Notary Public <i>191 Westville Ave Ept Danbury CT 06811</i>					



State of Connecticut
Department of Social Services
 55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility HANCOCK HALL		Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 31 STAPLES STREET, DANBURY, CT. 06810				
Report Prepared By		Phone Number	Date	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-794-9466		Report for Year Ended 9/30/2017	Page 2	of 37
Name of Facility (as shown on license) HANCOCK HALL		Address (No. & Street, City, State, Zip) 31 STAPLES STREET, DANBURY, CT. 06810		
License Numbers:	CCNH 2185-C	RHNS (Specify)	Medicare Provider No. 07-5414	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator JENNIFER MALONE-SEIXAS		Nursing Home Administrator's License No.:	00-1928	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire
 Corporate Owners**

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2017	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
FILOSA CARE CENTER, INC	31 STAPLES STREET, DANBURY, CT 06810	CONNECTICUT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
FRANK D. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06810	TREASURER	2100	
BARBARA A. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06810	SECRETARY	2250	
JENNIFER MALONE-SEIXAS	592 MANVILLE ROAD, PLEASANTVILLE, NY 10570	VICE-PRES	200	
MICHAEL D. MALONE	197 GUINEA ROAD, MONROE, CT 06468	PRESIDENT	250	
JOHN M. MALONE	22 NORTH DUTCHER STREET, IRVINGTON, NY 10533	DIRECTOR	200	
Names of Stockholders Owning at Least 10% of Shares				
FRANK D. MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06810	TREASURER	2100	
BARBARA A MALONE	105 MIDDLE RIVER ROAD, DANBURY, CT 06810	SECRETARY	2250	

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2017	Page 5	of 37
---	------------------------------	---	------------------	-----------------

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? Yes No If "No," explain fully why such allocation was not made.

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

ALLOCATION OF RELATED PARTY COMPANY SHARED EXPENSES ARE BASED ON THE NUMBER OF BEDS IN EACH FACILITY AS FOLLOWS: HANCOCK HALL (96 BEDS) 60% AND FILOSA (64 BEDS) 40%. MAINTENANCE AND HOUSEKEEPING: HANCOCK HALL (56,300 SQ FT) 59% AND FILOSA (39,605 SQ FT) 41%

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes No If "No," explain fully why such allocation was not made.

General Information and Questionnaire Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility HANCOCK HALL		License No. 2185-C		Report for Year Ended 9/30/2017			Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
GE CAPITAL/RICOH USA , PO BOX 41554, PHILADELPHIA, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	COPIER MACHINE LEASE	07/29/15	60 MONTH LEASE	7,345	7,345	
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes	<input checked="" type="radio"/> No
Total ***							7,345	

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
 ** Attach copies of newly acquired leases.
 *** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire
Accounting Basis

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2017	Page 7	of 37
----------------------------------	-----------------------	------------------------------------	-----------	----------

The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

Is the accounting basis for this period the same as for the previous period? Yes No If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CLIFTON LARSON ALLEN, LLP	300 CROWN COLONY DRIVE, STE 310, QUINCY MA 02169
2 CIRONE FRIEDBERG, LLP	24 STONY HILL ROAD, BETHEL, CT 06801
3 CLIFTON LARSON ALLEN, LLP	300 CROWN COLONY DRIVE, STE 310, QUINCY MA 02169
4	

Services Provided by This Firm (*describe fully*)

1 FINANCIAL STATEMENT REVIEW AND PREPARATION OF COST REPORT	\$ 24,450
2 PREPARATION OF ANNUAL PROPERTY TAX DECLARATION REPORT	\$ 1,500
3 401K FINANCIAL STATEMENT AUDIT	\$ 5,370
4	\$
	Charge for Services Provided
	\$ 31,320

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No PAGE 15, LINE 1.D

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 WIGGIN AND DANA LLP	203-498-4400
2	
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
 1 ONE CENTURY TOWER, NEW HAVEN, CT 06508
 2
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 HIPPA PRIVACY POLICES	\$ 3,548
2 HR MATTERS	\$ 564
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 4,112

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No PAGE 15, LINE 1.E

Schedule of Resident Statistics

Name of Facility HANCOCK HALL		License No. 2185-C			Report for Year Ended 9/30/2017				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	96	96			96	96			96	96		
B. On last day of THIS report period	96	96			96	96			96	96		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	94	94			94	94			94	94		
B. As of midnight of THIS report period	86	86			94	94			86	86		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,151	3,151			2,328	2,328			823	823		
B. Medicaid (Conn.)	22,895	22,895			16,874	16,874			6,021	6,021		
C. Medicaid (other states)												
D. Private Pay	6,465	6,465			5,260	5,260			1,205	1,205		
E. State SSI for RCH												
F. Other (Specify) COMMERCIAL INS/MEDICA	481	481			370	370			111	111		
G. Total Care Days During Period (3A thru F)	32,992	32,992			24,832	24,832			8,160	8,160		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	21	21			21	21						
B. Other Bed Reserve Days	19	19			13	13			6	6		
5. Total Resident Days (3G + 4A + 4B)	33,032	33,032			24,866	24,866			8,166	8,166		

Annual Report of Long-Term Care Facility

CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility HANCOCK HALL			License No. 2185-C			Report for Year Ended 9/30/2017			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid			Self-Pay			Other State Assisted				
	CCNH	RHNS	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	5	65				16							
Per Diem Rate													
a. One bed rm.						510.00							
b. Two bed rms.	638.00		245.43			480.00							
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									2,835	2,835			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									8,637	8,637			
D. Total Physical Therapy Treatments									11,472	11,472			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									193	193			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									247	247			
D. Total Speech Therapy Treatments									440	440			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									1,023	1,023			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									8,486	8,486			
D. Total Occupational Therapy Treatments									9,509	9,509			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2017	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	120,866					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	94,232	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	162,198	8,234				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	33,647	1,248				
c. Dietary Workers	416,017	26,601				
6. Housekeeping Service						
a. Head Housekeeper	48,110	1,229				
b. Other Housekeeping Workers	193,852	16,004				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	63,421	1,229				
b. Other Maintenance Workers	85,337	3,794				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	87,415	6,098				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant	68,764	1,320				
b. Other Accountants	144,672	4,900				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	202,164	4,272				
b. RN						
1. Direct Care	1,106,327	30,513				
2. Administrative**	108,871	2,868				
c. LPN						
1. Direct Care	792,975	26,776				
2. Administrative**	159,870	4,967				
d. Aides and Attendants	1,526,057	92,400				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	142,852	5,759				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	101,468	3,502				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	5,659,115	243,794				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

**Schedule A1 - Salary Information for Operators/Owners; Administrators,
Assistant Administrators and Other Related Parties***

Name of Facility				License No.	Report for Year Ended				Page	of
HANCOCK HALL				2185-C	9/30/2017				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
FRANK MALONE	7,860				TREASURER		A1	FILOSA CONV. HOME 13 HAKIM ST, DANBURY, CT		6,737
MICHAEL MALONE	69,579				PRESIDENT		A1	FILOSA CONV. HOME 13 HAKIM ST, DANBURY, CT	2,080	82,275
JENNIFER MALONE-SEIXAS	43,427				VICE PRESIDENT		A1	FILOSA CONV. HOME 13 HAKIM ST, DANBURY, CT		29,986
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include all employment worked during the cost year.

**Schedule A1 - Salary Information for Operators/Owners; Administrators,
Assistant Administrators and Other Related Parties***

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
HANCOCK HALL				2185-C		9/30/2017			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
JENNIFER MALONE-SEIXAS	94,232					2,080	A2			
Section IV - Assistant Administrators										

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include all other employment worked during the cost year.

*** If more than one Administrator is reported, include dates of employment for each.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
HANCOCK HALL	2185-C	9/30/2017	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian	45,979	1,022				
2. Dentist	6,413	137				
3. Pharmacist	6,675	141				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	221,525	3,674				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	40,200	279				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)	1,140	6				
2. Pharmaceutical Committee (Quarterly meetings)	1,140	6				
3. Staff Development Committee (Once annually)	570	4				
e. Other (Specify) SERVICES	16,000	89				
9. Speech Therapist						
a. Resident Care	16,341	976				
b. Other						
10. Occupational Therapist						
a. Resident Care	175,387	2,999				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	1,200	24				
B-13 Total Fees Paid in Lieu of Salaries	532,570	9,357				

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

*** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

Report of Expenditures
Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis*

Name of Facility HANCOCK HALL		License No. 2185-C		Report for Year Ended 9/30/2017	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
DEBORAH LYON, 7 NORTH BRANCH RD, NEWTOWN, CT 06470	DIETICIAN - DIETARY NEEDS AND REPORTS	<input type="radio"/>	<input checked="" type="radio"/>			
SERAFIMA GLOUZGAL,MD, 388 GROVE ST, RIDGFIELD, CT 06877	COORDINATION OF MEDICAL CARE FOR RESIDENTS	<input type="radio"/>	<input checked="" type="radio"/>			
DANIEL WOLLMAN,MD, 580 LONG HILL AVE, SHELTON, CT 06474	COORDINATION OF MEDICAL CARE FOR RESIDENTS	<input type="radio"/>	<input checked="" type="radio"/>			
LAURIE A FIGLIOLA, 12 GRAYS FARM ROAD, WESTON, CT 06883	DIETICIAN - DIETARY NEEDS AND REPORTS	<input type="radio"/>	<input checked="" type="radio"/>			
ALLIANCE REHAB OF CT, 1520 KENSINGTON RD, SUITE105, OAKBROOK,	PT, OT AND SPEECH EVALUATIONS AND TREATMENT	<input type="radio"/>	<input checked="" type="radio"/>			
SYMBRIA REHAB, 28100 TORCH PARKWAY, WARRENVILLE, IL 60555	PT, OT AND SPEECH EVALUATIONS AND TREATMENT	<input type="radio"/>	<input checked="" type="radio"/>			
ORESTES ARCUNI, MD , 4 BARTRAM DRIVE, WEST REDDING, CT 06896	PSYCHIATRIC EVALUATIONS AND SERVICES	<input type="radio"/>	<input checked="" type="radio"/>			
REV. DAVID FRANKLIN, ST. JOSEPH'S ROMAN CATHOLIC CHURCH, 8 ROBINSON	MASS AND CLERGY VISITS TO FACILITY RESIDENTS	<input type="radio"/>	<input checked="" type="radio"/>			
MEMBERS OF ORGANIZED MEDICAL STAFF (ROBERT RUXIN, MD/ JEANINE	INFECTION CONTROL REVIEW, PHARMACEUTICAL REVIEW,	<input type="radio"/>	<input checked="" type="radio"/>			
OMNICARE PHARMACY, 525 KNOTTER DRIVE, CHESHIRE, CT	GENERAL SUPERVISION OF DRUG ADMINISTRATION	<input type="radio"/>	<input checked="" type="radio"/>			
VALURX PHARMACY, 54 TUTTLE PLACE, MIDDLETOWN, CT 06457	GENERAL SUPERVISION OF DRUG ADMINISTRATION	<input type="radio"/>	<input checked="" type="radio"/>			
HEALTH DRIVE DENTAL GROUP, 888 WORCHESTER ST, WELLESLEY, MA	EVALUATION AND DENTAL GROUP	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			

* Use additional sheets if necessary.
 ** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
HANCOCK HALL	2185-C	9/30/2017	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 174,814	174,814		
2. Disability Insurance	\$ 25,372	25,372		
3. Unemployment Insurance	\$ 65,196	65,196		
4. Social Security (F.I.C.A.)	\$ 425,928	425,928		
5. Health Insurance	\$ 284,065	284,065		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 30,285	30,285		
8. Uniform Allowance	\$ 10,793	10,793		
9. Other (<i>Specify</i>) See Attached Schedule	\$ 8,596	8,596		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 100,634	100,634		
d. Accounting and Auditing	\$ 31,320	31,320		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 4,112	4,112		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 34,923	34,923		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 17,989	17,989		
2. Cellular Phones	\$ 3,905	3,905		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 616,883	616,883		
Subtotal	\$ 1,834,815	1,834,815		

* Facility should self-disallow the expense on Page 28 of the Cost Report.

(Carry Subtotals forward to next page)

C. Expenditures Other Than Salaries (cont'd) - Administrative and General

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2017	Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,834,815	1,834,815	
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$ 6,923	6,923		
2. Holiday Parties for Staff	\$ 1,676	1,676		
3. Gifts to Staff and Residents	\$ 13,418	13,418		
4. Employee Travel	\$ 267	267		
5. Education Expenses Related to Seminars and Conventions	\$ 7,701	7,701		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 445	445		
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 8,644	8,644		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$ 297	297		
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 29,541	29,541		
4. Fund-Raising***	\$			
5. Medical Records	\$ 4,948	4,948		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 11,099	11,099		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 10,149	10,149		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$ 1,044	1,044		
10. Contributions*** See Attached Schedule	\$ 3,495	3,495		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 29,049	29,049		
12. Administrative Management Services**	\$			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 139,225	139,225		
C-14 Total Administrative & General Expenditures		\$ 2,102,736	2,102,736	

* Do not include Subscriptions, which should go in item 9.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

*** Facility should self-disallow the expense on Page 28 of the Cost Report.

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
PROMOTION/PUBLIC RELATIONS	\$ 29,541		
Total Other Advertising	\$ 29,541	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 6,901		
CATRD (CT Association of Therapeutic Recreation Directors)	\$ 40.00		
ASHHRA (American Society for Healthcare HR Administration)	\$ 160.00		
COSTCO	\$ 110.00		Disallow
CSP (Certify Safty Professional)	\$ 40.00		
NOTARY FEE	\$ 60.00		
SHRM(Society for HR Management)	\$ 199.00		
2017-2018 ANNUAL RENEWAL FOOD SERVICE OPERATORS	\$ 300.00		
ALTCFM (Association for Long Term Care Financial Manager)	\$ 85.00		
BBB ACCREDITED BUSINESS DUES	\$ 300.00		Disallow
CT SECRETARY OF STATE - BUSINESS ENTITY REPORT	\$ 90.00		
AMAZON PRIME MEMBERSHIP	\$ 7.00		Disallow
STATE OC CT DEPT OF PUBLIC HEALTH/ JENNIFER MALONE-SEIXAS ADMIN LICENSE	\$ 205.00		
FINGERPRINTING/LICENSE FEE	\$ 37.00		
AANAC (American Association of Nurse Assessment Coordination)	\$ 398.00		
MEDICAL STAFF OF DANBURY HOSPITAL	\$ 275.00		

BUSINESS ENTITY REFINANCE FEE	\$ 78.00		Disallow
NURSE PRACTITIONER/PHYSICIAN ASST MEMBERSHIP	\$ 263.00		
APIC (Association for Professionals in Infection Control and Epidemiology)	\$ 351.00		
CT BUSINESS ENTITY FEE	\$ 250.00		
Total Dues	\$ 10,149	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
NONNEWAUG CHEER REGION 14	\$ 100.00		
WESTERN CT HEALTH NETWORK FOUND	\$ 1,500.00		
INSTITUTE FOR HOLISTIC HEALTH STUDIES	\$ 50.00		
THE HORD FOUNDATION INC	\$ 1,320.00		
SAINT JOSEPH CHURCH	\$ 500.00		
YALE-NEW HAVEN HOSPITAL	\$ 25.00		
Total Contributions	\$ 3,495	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
POSTAGE METER RENTAL AND COPIER SUPPLIES	\$ 11,738		
OFFICE SMALL EQUIPMENT	\$ 3,425		
CABLE TV	\$ 21,430		
REPAIRS/SERVICE OFFICE EQUIPMENT:			
SOFTWARE LICENSES AND MAINTENANCE	\$ 34,668		
TELEPHONE SYSTEM MAINTENANCE	\$ 2,476		
BUSINESS INTERNET	\$ 3,676		
COMPUTER MAINTENANCE AND HOSTING	\$ 17,215		
OFFICE EQUIPMENT REPAIRS	\$ 850		
PAYROLL SERVICE FEES	\$ 22,232		
MISCELLANEOUS	\$ 7,366		
FACILITY AND OTHER FEES	\$ 560		
BANK AND MERCHANT FEES	\$ 5,925		
RESIDENT RELATED MISCELLANEOUS EXPENSES	\$ 1,394		
LOSS ON DISPOSAL OF EQUIPMENT	\$ 6,270		
Total Other Administrative and General	\$ 139,225	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2017	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

*** In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs (See Note on Page 5)

Name of Facility HANCOCK HALL		License No. 2185-C	Report for Year Ended 9/30/2017	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$	297,710	297,710		
2. Non-Food Supplies	\$	40,198	40,198		
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Management Services**					
d. Other (Specify) _____ DIETARY EQUIPMENT RENTAL	\$	3,199	3,199		
2E. Total Dietary Expenditures (2a + b + c + d)		\$	341,107	341,107	
2F. Dietary Questionnaire					
G. Resident Meals: Total no. of meals served per day:*		272	272		
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs
(See Note on Page 5)

Name of Facility HANCOCK HALL		License No. 2185-C	Report for Year Ended 9/30/2017		Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)	
3. Laundry						
a. In-House Processing*		Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	12,066	12,066		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.				
		Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.				
		Amt. \$				
4. Repair and/or purchase of linens.***		Lbs.				
		Amt. \$	17,411	17,411		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Management Services**		\$				
d. Other (Specify) LAUNDRY EQUIPMENT RENTAL		\$	8,295	8,295		
3E. Total Laundry Expenditures (3a + b + c + d)		\$	37,772	37,772		
3F. Laundry Questionnaire						
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
 All allocations should add to total recorded in 3E.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

*** Pounds of Laundry only required for multi-level facilities.

**C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care
 Basis for Allocation of Costs (See Note on Page 5)**

Name of Facility	License No.	Report for Year Ended	Page	of	
HANCOCK HALL	2185-C	9/30/2017	20	37	
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced	56,300	56,300		
a. In-House Care	by Personnel				
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	34,073	34,073		
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
	Amt. \$				
c. Management Services*	\$				
d. Other (<i>Specify</i>)	\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)	\$	34,073	34,073		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from OMNICARE, VALUERX, DANBURY EYE PHYSICIANS & SURGEONS	\$	120,229	120,229		
b. Medicine Cabinet Drugs	\$	1,969	1,969		
c. Medical and Therapeutic Supplies	\$	169,309	169,309		
d. Ambulance/Limousine****	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other****	\$	24,700	24,700		
f. X-rays and Related Radiological Procedures****	\$	4,120	4,120		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory****	\$	7,272	7,272		
i. Recreation	\$	13,232	13,232		
j. Other (<i>Specify</i>)**** See Attached Schedule	\$	26,810	26,810		
5K. Total Resident Care Expenditures (5a - 5j)	\$	367,641	367,641		

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
TECH COMPONENTS - MEDICARE PART A	\$ 4,305		
DME RENTAL	\$ 3,756		
NURSING EQUIPMENT RENTAL	\$ 18,749		
Total Other Resident Care	\$ 26,810	\$ -	\$ -

Report of Expenditures
Schedule C-2 - Individuals or Firms Providing Services by Contract *

Name of Facility HANCOCK HALL		License No. 2185-C		Report for Year Ended 9/30/2017			Page of 21 37			
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
CLIFTON LARSON ALLEN LLP	DRIVE, STE 310, QUINCY MA 02169	<input type="radio"/>	<input checked="" type="radio"/>		ACCOUNTING SERVICES	29,820			15	7
NETWORK SYNERGY	TRUMBULL, CT 06611	<input type="radio"/>	<input checked="" type="radio"/>		SERVICES AND MAINTENANCE	10,217			16	M.13
DEBORAH B.LYON, RD	RD, NEWTOWN, CT 06470	<input type="radio"/>	<input checked="" type="radio"/>		DIETICIAN - DIETARY NEEDS AND REPORTS	28,238			13	B.1
SYMBRIA REHAB	PARKWAY, WARRENVILLE, IL	<input type="radio"/>	<input checked="" type="radio"/>		EVALUATIONS AND TREATMENT	306,416			13	
ALLIANCE REHAB OF CONNECTICUT	RD, SUITE105, OAKBROOK, IL 60523	<input type="radio"/>	<input checked="" type="radio"/>		EVALUATIONS AND TREATMENT	106,476			13	
SERAFIMA M. GLOUZGAL	RIDGEFIELD, CT 06877	<input type="radio"/>	<input checked="" type="radio"/>		MEDICAL DIRECTOR	27,600			13	B.8.A
CELTIC CONSULTING LLC	TORRINGTON, CT 06790	<input type="radio"/>	<input checked="" type="radio"/>		MDS COMPILANCE	23,495			16	M.11
CENTER FOR COMPREHENSIVE CARE, LLC	580 LONG HILL AVE, SHELTON, CT 06474	<input type="radio"/>	<input checked="" type="radio"/>		MEDICAL DIRECTOR	12,600			13	B.8.A
MATRIXCARE	MINNEAPOLIS, MN, 55480	<input type="radio"/>	<input checked="" type="radio"/>		SOFTWARE MAINTENANCE	14,000			16	M.13
LAURIE A FIGLIOLA RDN	ROAD, WESTON, CT 06883	<input type="radio"/>	<input checked="" type="radio"/>		DIETICIAN - DIETARY NEEDS AND REPORTS	17,741			13	B.1
ORESTES J. ARCUNI	WEST REDDING, CT 06896	<input type="radio"/>	<input checked="" type="radio"/>		EVALUATIONS AND SERVICES	16,000			13	B.8.E
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

C. Expenditures Other Than Salaries (cont'd) - Maintenance and Property

Name of Facility	License No.	Report for Year Ended			Page	of
HANCOCK HALL	2185-C	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 105,930	105,930				
b. Heat	\$ 55,743	55,743				
c. Light & Power	\$ 78,742	78,742				
d. Water	\$ 58,281	58,281				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 7,345	7,345				
f. Other (<i>itemize</i>)	\$ 47,644	47,644				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 353,685	353,685				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 37,638	37,638				
b. Building & Building Improvements	\$ 67,054	67,054				
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 94,807	94,807				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 199,499	199,499				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 1,582	1,582				
c. Leasehold Improvements	\$ 81,773	81,773				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 83,355	83,355				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 672,746	672,746				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 110,557	110,557				
c. Personal property taxes	\$ 15,060	15,060				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,081,217	1,081,217				

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
OUTSIDE GROUND MAINTENACE	\$ 362		
REFUSE REMOVAL	\$ 25,882		
EXTERMINATING	\$ 3,382		
BED AND CHAIR ALARMS	\$ 1,755		
REPAIR/MAINTENACE GROUNDS	\$ 16,263		
Total Other Repairs and Maintenance	\$ 47,644	\$ -	\$ -

Depreciation Schedule

Name of Facility HANCOCK HALL		License No. 2185-C			Report for Year Ended 9/30/2017			Page 23	of 37			
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
A. Land Improvements												
1. Acquired prior to this report period		512,490		512,490	255,189	SL	VARIOUS	37,638				
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal									37,638			
B. Building and Building Improvements												
1. Acquired prior to this report period		5,118,999	7,000	5,111,999	5,044,945	SL	VARIOUS	67,054				
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal									67,054			
C. Non-Movable Equipment												
1. Acquired prior to this report period		138,445		138,445	138,445							
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal												
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. 2015 Ford Van Model #E350 SU		X		4	2015	62,400		62,400	24,375	SL	4	15,600
b. 2013 Hyundai Sante Fe (opening bal)		X		4	2016	25,396		25,396	4,473	SL	3	8,225
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period						940,188		940,188	686,567	SL	VARIOUS	59,863
b. Disposals (attach schedule)						(75,198)		(75,198)	(68,467)	SL	VARIOUS	1,364
c. Acquired during this report period (attach schedule)						102,525		102,525		SL	VARIOUS	9,755
D-3. Subtotal												94,807
E. Total Depreciation												199,499

HANCOCK HALL
9/30/2017

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Land Improvement		\$ -		\$ - *
Deletions:				
Total deletions for Land Improvement		\$ -		\$ - **

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Building Improvement		\$ -		\$ - *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		\$ -		\$ - *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility HANCOCK HALL			License No. 2185-C		Report for Year Ended 9/30/2017			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Loan related to parking lot improvement	5	2010	10	15,824	12,145			1,582	
2.									
3.									
B-4. Subtotal									1,582
C. Leasehold Improvements and Other									
1. Acquired prior to this report period			VARIOUS	1,278,584	677,958	ACTUAL LIFE	VARI	80,802	
2. Disposals (attach schedule)			VARIOUS	(139,847)	(138,266)	ACTUAL LIFE	VARI	677	
3. Acquired during this report period (attach schedule)			VARIOUS	6,788		ACTUAL LIFE	VARI	294	
C-4. Subtotal									81,773
D. Total Amortization									83,355

* Straight-line method must be used.

** Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

C. Expenditures Other Than Salaries (cont'd) - Property Questionnaire

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2017	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased		02/23/84		
2. Date Structure Completed		03/09/84		
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure		03/09/84		
5. Total Licensed Bed Capacity		96		
6. Square Footage		56,300		
7. Acquisition Cost				
a. Land		170,000		
b. Building		4,551,697		
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of 9/30/2017	2,858,746			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)	FIXED			
h. Date of Refinancing	12/22/16			
i. New Interest Rate	3.95%			
j. Term of Mortgage (number of years)	10			
k. Amount of Principal Borrowed	3,120,000			
l. Principal Outstanding on Note Paid-Off	2,997,179			
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

C. Expenditures Other Than Salaries (cont'd) - Interest

Name of Facility		License No.	Report for Year Ended			Page	of
HANCOCK HALL		2185-C	9/30/2017			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$ 5,450	5,450				
Name of Lender		Rate					
UNION SAVINGS BANK #72241		4.35%					
Address of Lender							
225 MAIN STREET DANBURY, CT 06810							
2. Second Mortgage		\$ 525	525				
Name of Lender		Rate					
UNION SAVINGS BANK #28040		4.00%					
Address of Lender							
225 MAIN STREET DANBURY, CT 06810							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$ 5,975	5,975				

(Carry Subtotals forward to next page)

C. Expenditures Other Than Salaries (cont'd) - Interest and Insurance

Name of Facility	License No.	Report for Year Ended			Page	of
HANCOCK HALL	2185-C	9/30/2017			27	37
Item	Total	CCNH	RHNS	(Specify)		
Subtotals Brought Forward:	5,975	5,975				
12. C. Movable Equipment						
1. Automotive Equipment	\$ 2,058	2,058				
A. Item	Rate	Amount				
PATIENT VAN	4.00%	50,000				
Lender						
UNION SAVINGS BANK #72241						
Address of Lender						
225 MAIN STREETDANBURY, CT 06810						
2. Other (Specify)	\$ 1,544	1,544				
A. Item	Rate	Amount				
2013 HYUNDAI SANTA FE	4.00%	22,396				
Lender						
CHASE AUTO FINANCE						
Address of Lender						
PO BOX 78068PHOENIX, AZ 85062						
B. Item	Rate	Amount				
PHONE SYSTEM	5.00%	53,441				
Lender						
CAROUSEL INDUSTRIES						
Address of Lender						
PO BOX 790448ST LOUIS, MO 63179						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	\$ 3,602	3,602				
12. D. Other Interest Expense (Specify)	\$ 9,063	9,063				
SEE ATTACHED						
13. Total All Interest Expense (12B7 + 12C3 + 12D)	\$ 18,640	18,640				
14. Insurance						
a. Insurance on Property (buildings only)	\$ 14,929	14,929				
b. Insurance on Automobiles	\$ 3,886	3,886				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)	\$ 10,371	10,371				
2. Fire and Extended Coverage	\$ 31,257	31,257				
3. Other (Specify)	\$ 14,196	14,196				
SEE ATTACHED						
14d. Total Insurance Expenditures (14a + b + c)	\$ 74,639	74,639				
15. Total All Expenditures (A-13 thru C-14)	\$ 10,603,195	10,603,195				

D. Adjustments to Statement of Expenditures

Name of Facility HANCOCK HALL				License No. 2185-C	Report for Year Ended 9/30/2017	Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.	10	A.1	Salaries not related to Resident Care	\$ 120,866	120,866		
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 8,407	8,407		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1.C	Bad Debts	\$ 100,634	100,634		
10.	15	1.E	Accounting & Legal	\$ 564	564		
11.			Telephone	\$			
12.	15	H.2	Cellular Telephone	\$ 3,185	3,185		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	L.3	Gifts, flowers and coffee shops	\$ 7,507	7,507		
15.	16	L.5	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 4,363	4,363		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	M.3	Unallowable Advertising *	\$ 29,541	29,541		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	M.10	Fund Raising / Contributions	\$ 3,495	3,495		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 30,121	30,121		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 308,683	308,683		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A.2	JENNIFER MALONE-SEIXAS (EXCESS OVER LIMIT)	\$ 8,407		
Total Other Salaries Adjustment			\$ 8,407	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Fees Adjustments			\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M.13	MISCELLANEOUS	\$ 7,366		
16	M.13	BANK AND MERCHANT FEES	\$ 5,925		
16	M.13	RESIDENT RELATED MISCELLANEOUS EXPENSES	\$ 1,394		
16	M.13	LOSS ON DISPOSAL OF EQUIPMENT	\$ 6,270		
15	1.A.4	FICA ON OWNER/OPERATOR SALARIES	\$ 8,671		
16	M.8	DUES AND MEMBERSHIP FEES	\$ 495		
Total Other A&G Adjustments			\$ 30,121	\$ -	\$ -

D. Adjustments to Statement of Expenditures (cont'd)

Name of Facility HANCOCK HALL				License No. 2185-C	Report for Year Ended 9/30/2017	Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 308,683	308,683		
Page 20 - Resident Care Supplies***							
27.	20	5.A.2	Prescription Drugs	\$ 120,229	120,229		
28.			Ambulance/Limousine	\$			
29.	20	5.D	X-rays, etc	\$ 4,120	4,120		
30.	20	5.H	Laboratory	\$ 7,272	7,272		
31.	20	5.C	Medical Supplies	\$ 4,933	4,933		
32.	20	5.E.2	Oxygen (non emergency)	\$ 24,700	24,700		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 8,061	8,061		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 1,377	1,377		
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	14.C.	Property Insurance	\$ 8,170	8,170		
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 674	674		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 488,219	488,219		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

HANCOCK HALL
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5.J	TECH COMPONENTS - MEDICARE PART A	\$ 4,305		
20	5.J	DME RENTAL	\$ 3,756		
Total Other Ancillary Costs			\$ 8,061	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7.D	2013 HYUNDAI SANTA FE - DEPRECIATION CORRECTION	\$ 240		
22	7.D	CAPITIZATION OF TELEPHONE - DEPRECIATION CORRECTION (PY)	\$ 1,137		
Total Excess Movable Equipment Depreciation			\$ 1,377	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	C.3.D	FINANCE CHARGES	\$ 674		
Total Other Adjustments			\$ 674	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2017		Page 30	of 37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 10,829,520	10,829,520			
b. Medicaid Room and Board Contractual Allowance **	\$ (5,205,299)	(5,205,299)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,512,051	1,512,051			
b. Medicare Room and Board Contractual Allowance **	\$ 457,995	457,995			
4. a. Private-Pay Residents and Other	\$ 3,395,192	3,395,192			
b. Private-Pay Room and Board Contractual Allowance **	\$ (128,717)	(128,717)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$				
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 96,613	96,613			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (27,143)	(27,143)			
c. Physical Therapy - Non-Medicare	\$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 11,414	11,414			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (1,838)	(1,838)			
c. Speech Therapy - Non-Medicare	\$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 38,927	38,927			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (14,309)	(14,309)			
c. Occupational Therapy - Non-Medicare	\$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$ 4,329	4,329			
b. Other (<i>Specify</i>) - Non-Medicare	\$ (5,388)	(5,388)			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 10,963,347	10,963,347			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 187	187			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 106	106			
V. Total Other Revenue (1 thru 8)	\$ 293	293			
VI. Total All Revenue (III +V)	\$ 10,963,640	10,963,640			

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	FLU/PNEUMOVAX AND ADMINISTRATION	\$ 4,329		
	Total Other Resident Revenue - Medicare	\$ 4,329	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	PRIVATE PAY PRIOR YEAR ADJUSTMENTS	\$ 404		
	MEDICAID PRIOR YEAR ADJUSTMENTS	\$ (5,792)		
	Total Other Resident Revenue	\$ (5,388)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	UNION SAVINGS BANK	15,187	\$ 173		
	UNION SAVINGS BANK -Reserve account	16,635	\$ 7		
	MISCELLANEOUS		\$ 7		
	Total Interest Income		\$ 187	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	REFUND MOBILE AUDIOLOGY	\$ 106		
	Total Other Revenue	\$ 106	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
HANCOCK HALL	2185-C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	33,768
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	759,475
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	79,198
a. PREPAID INSURANCE	26,614			
b. PREPAID EXPENSES	34,875			
c. REQUIRED PAYMENT	17,709			
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	700
EMPLOYEE ADVANCE	700			
A-9. Total Current Assets (Lines A1 thru 8)			\$	873,141
B. Fixed Assets				
1. Land				
2. Land Improvements	*Historical Cost	512,490	\$	219,663
	Accum. Depreciation	292,827		Net
3. Buildings	*Historical Cost		\$	
	Accum. Depreciation			Net
4. Leasehold Improvements	*Historical Cost	1,145,525	\$	524,737
	Accum. Depreciation	620,788		Net
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Depreciation			Net
6. Movable Equipment	*Historical Cost	967,515	\$	281,161
	Accum. Depreciation	686,354		Net
7. Motor Vehicles	*Historical Cost	87,796	\$	35,123
	Accum. Depreciation	52,673		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,060,684

* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
HANCOCK HALL	2185-C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	1,933,825
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	170,000
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	5,118,999		
	Accum. Depreciation	5,111,999	Net	\$ 7,000
4. Non-Movable Equipment				
	*Historical Cost	138,445		
	Accum. Depreciation	138,445	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	177,000
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care <i>(itemize)</i>			\$	

6. Loans to Owners or Related Parties <i>(itemize)</i>			\$	3,780
Name and Address		Amount	Loan Date	
Filosa For Nursing and Rehabilitation		3,780		
7. Other Assets <i>(itemize)</i>			\$	90,418
BED LICENSE (NET OF AMORTIZATION)		88,000		
FINANCING COSTS (NET OF AMORTIZATIO		2,418		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	94,198
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	2,205,023

* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

G. Balance Sheet (cont'd)

Name of Facility HANCOCK HALL		License No. 2185-C	Report for Year Ended 9/30/2017	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	361,623
2. Notes Payable (<i>itemize</i>)				\$	117,484
USB LINE OF CREDIT					74,119
USB FOR PARKING LOT (S/T PORTION)					43,365
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	30,941
Name of Lender		Purpose	Amount	Date Due	
SEE ATTACHED			30,941		
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	263,577
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	4,080
6. Accrued Payroll Taxes Payable				\$	20,195
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	26,591
ACCRUED EXPENSES					26,591
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	824,491

* Business Income Tax (not that withheld from employees). Attach copy of owner's Federal Income Tax Return.

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility HANCOCK HALL		License No. 2185-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount	
Total Brought Forward:				824,491	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
				\$	51,835
Name of Lender		Purpose	Amount	Date Due	
SEE ATTACHED			51,835		
2. Mortgages Payable					
				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)					
				\$	
Name and Address of Lender		Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)					
USB FOR PARKING LOT (L/T PORTION)			72,630	\$	72,630
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$	124,465
C. Total All Liabilities (Lines A-13 + B-5)				\$	948,956

G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
HANCOCK HALL	2185-C	9/30/2017	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	170,000
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	7,000
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	177,000
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	257,500
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	460,122
6. Gain or Loss for Period	10/1/2016	thru 9/30/2017	\$	360,445
7. Total Net Worth			\$	1,079,067
C. Total Reserves and Net Worth			\$	1,256,067
D. Total Liabilities, Reserves, and Net Worth			\$	2,205,023

H. Changes in Total Net Worth

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2017	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	801,854
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	10,963,640
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	10,603,195
D. Net Income or Deficit			\$	360,445
E. Balance			\$	1,162,299
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	83,232
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
SEE ATTACHED			83,232	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	83,232
H. Balance at End of Period			\$	1,079,067
				09/30/17

I. Preparer's/Reviewer's Certification

Name of Facility HANCOCK HALL	License No. 2185-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer 	Title CFO	Date Signed 2/12/18		
Printed Name of Preparer BENJAMIN CHIANESE, CPA				
Address 31 STAPLES STREET, DANBURY, CT 06810		Phone Number 203-794-9466		